FORMAT VERSION 06-95

AIDS MEDI-CAL WAIVER
0183.90.R2.01
FIVE-YEAR RENEWAL
CALENDAR YEARS 2002-2006

SUBMITTED APRIL 2004

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES
OFFICE OF AIDS
Effective June 1, 2004

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SECTION 1915(c) WAIVER RENEWAL REQUEST

1. The State of California requests a Medicaid home and community-based services waiver under the authority of Section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a.___ Yes b.__X__ No

   If yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

   This waiver is requested for a period of (check one):

   a.___ 3 years (initial waiver)

   b.__X__ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a.__X__ Nursing facility (NF)

   b.___ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

   c.__X__ Hospital

   d.__X__ NF (served in hospital)

   e.___ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

   a.__ Aged (age 65 and older)

   b.__X__ Disabled

   c.___ Aged and disabled

d.___ Mentally retarded

e.___ Developmentally disabled

f.___ Mentally retarded and developmentally disabled

g.___ Chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

a.___ Waiver services are limited to the following age groups (specify):

b. X Waiver services are limited to individuals with the following disease(s) or condition(s) (Specify):
   1) Individuals who are at the Intermediate Care Facility (ICF) or Skilled Nursing Facility (SNF) level of care are hereafter known as Nursing Facility (NF) level of care; or
   2) Individuals who are at the hospital level of care; and
   3) Adults with a diagnosis of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) with signs, symptoms, or disabilities related to HIV disease or HIV disease treatment; or
   4) Children Under 13 Years of Age with HIV/AIDS with Category A, B, or C classification.

c.___ Waiver services are limited to individuals who are mentally retarded or developmentally disabled who currently reside in general NFs but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by Public Law 100-203, to require active treatment at the level of an ICF/MR.

d. X Other criteria. (Specify): Clients will receive waiver services only if they meet all of the following criteria:
   1) Medi-Cal eligibility requirements;
   2) When the client has a third party source of payment, coverage for health care benefits similar to those available under the AIDS Waiver must be accessed prior to utilization of AIDS Waiver services; and
   3) At a minimum:
      a) the NF Level of Care criteria or above (see page 3) and must have a rating of 60 or less on the Cognitive and Functional Ability Scale (see pages 4-6) or
      b. Category "A, B, or C" (i.e., mildly, moderately, or severely symptomatic) on the CDC Classification System for HIV Infection in Children under 13 years of Age (see pages 7-9).

AIDS MEDI-CAL WAIVER PROGRAM
NURSING FACILITY LEVEL OF CARE (NF/LOC)
Effective May 1997

To qualify for Nursing Facility care services, the complexity of the client's medical problems is such that he or she needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Nursing Facility care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual client independence to the extent of his or her ability. Use the following description as a guide for determining appropriate placement:

1. Medications may be mainly supportive or stabilizing but still require professional nurse observation for response and effect on an intermittent basis.

2. Diet may be of a special type; clients may need assistance in feeding him/herself.

3. The client may require assistance or supervision in personal care, such as in bathing or dressing.

4. The client may need encouragement in restorative measures for increasing and strengthening his or her functional capacity to work toward greater independence.

5. The client may have some degree of vision, hearing or sensory loss.

6. The client may have limitation in movement.

7. The client may be incontinent of urine and/or bowels.

8. The client may exhibit some mild confusion or depression; however, his or her behavior must be stabilized to such an extent that it poses no threat to him/herself or others.

DEFINITIONS, COGNITIVE AND FUNCTIONAL ABILITY SCALE FOR PERSONS WITH HIV/AIDS

1.**NUTRITION**

Independent - Able to do all meal planning, shopping, and preparation. 11
Minimal Assistance - Knowledge deficit or needs assistance with planning or shopping. 7
Moderate Assistance - Home delivered meals, needs assistance with meal preparation, or physiological impairment such as nausea, vomiting, weight loss or mal-nourishment. 5
Considerable Assistance - Alternative or artificial therapy including tube feedings, or must be fed by others. 3
Totally Dependent - IV fluids or TPN only or no intake. 1

2.**HYGIENE**

Independent - Able to perform personal hygiene and dressing without assistance. 11
Minimal Assistance - Tires easily, needs adaptive devices, and/or supervision. 7
Moderate Assistance - Able to perform personal hygiene and dressing with assistance of one person. 5
Considerable Assistance - Assistance with entire bath and dressing. Cannot stand independently. 3
Totally Dependent - Bed bath only. Does not or should not be dressed. 1

3.**EXCRETION**

Independent - Fully continent. Up to bathroom alone. Able to complete all toileting functions without assistance. 11
Minimal Assistance - Continent with assistance. Tires easily. 7
Moderate Assistance - Stress or occasional incontinence. May need some assistance or adaptive device. 5
Considerable Assistance - Frequent incontinence. Needs adaptive devices assistance. 3
Totally Dependent - No bowel or bladder control. Needs maximum assistance. 1

4.**ACTIVITY**

Independent - No physical limitations. 11
Minimal Assistance - Ambulates independently but requires frequent rest and/or adaptive devices. Tires easily. 7
Moderate Assistance - Unable to ambulate without assistance and/or adaptive devices. Unsteady gait. 5
Considerable Assistance - Unable to ambulate or falls frequently. 1

5.**TREATMENTS/MEDICATIONS**

Independent - No or self-administered medications. Able to access medical services without assistance. 11
Minimal Assistance – Self-administers medications/treatments and requires intermittent instruction and observation. May need reminder to take medications. 7

DEFINITIONS, COGNITIVE AND FUNCTIONAL ABILITY SCALE FOR PERSONS WITH HIV/AIDS

Moderate Assistance - Administration requires supervision and/or assistance. 5
Considerable Assistance - Frequent administration of medications/treatments with maximum assistance. 3
Totally Dependent - No self-administration. Comfort measures only. 1

6.**TEACHING**
Independent - Able to obtain and understand information independently. 11
Minimal Assistance - Knowledge deficit. Guidance needed in accessing information and resources. 7
Moderate Assistance - Moderate teaching required with ongoing reinforcement. 5
Considerable Assistance - Detailed in-depth teaching required. Communication barriers/sensory defects. 3
Totally Dependent - Unresponsive. 1

7.**SUPPORT SYSTEMS**
Independent - Independently accesses available support systems. 11
Minimal Assistance - Guidance needed in accessing available support systems. 7
Moderate Assistance - Some support systems in place. Occasional intervention. 5
Considerable Assistance - Limited resources available. Ongoing assistance required accessing support systems. More than one HIV-infected household member. 3
Totally Dependent - No identifiable support systems. 1

8.**MENTAL STATUS**
Independent - Alert and oriented. 11
Minimal Assistance - Deficit in concentration, thought process, memory, and/or insight. 7
Moderate Assistance - Substantial deficit in concentration, thought process, memory and/or insight requiring supervision and/or assistance. Safety risk. 5
Considerable Assistance - Responses minimal. Disabling dementia or other psychiatric diagnosis. 3
Totally Dependent - Unresponsive. 1

9.**BEHAVIOR**
Independent - Non-compliant. Unpredictable, socially inappropriate. Self-directed, cooperative, active in decision-making. 11
Minimal Assistance - Socially appropriate. May require encouragement to initiate interactions but follows through. 7
Moderate Assistance - Passive, resistant, or poor compliance. Requires continuous encouragement to follow through. 5
Considerable Assistance - Non-compliant. Unpredictable, socially inappropriate. 3
Totally Dependent - Unresponsive. 1

Cognitive and Functional Ability Scale For Persons With HIV Disease/ AIDS

DATE ASSESSED/INITIALS

AREAS ASSESSED DATE							
1. **NUTRITION** Independent 11 Minimal Assistance 7 Moderate Assistance 5 Considerable Assistance 3 Totally Dependent 1							
2. **HYGIENE** Independent 11 Minimal Assistance 7 Moderate Assistance 5 Considerable Assistance 3 Totally Dependent 1							
3. **EXCRETION** Independent 11 Minimal Assistance 7 Moderate Assistance 5 Considerable Assistance 3 Totally Dependent 1							
4. **ACTIVITY** Independent 11 Minimal Assistance 7 Moderate Assistance 5 Considerable Assistance 3 Totally Dependent 1							
5.**TREATMENT/MEDICATION** Independent 11 Minimal Assistance 7 Moderate Assistance 5 Considerable Assistance 3 Totally Dependent 1							
6. **TEACHING** Independent 11 Minimal Assistance 7 Moderate Assistance 5 Considerable Assistance 3 Totally Dependent 1							
7. **SUPPORT SYSTEMS** Independent 11 Minimal Assistance 7 Moderate Assistance 5 Considerable Assistance 3 Totally Dependent 1							
8. **MENTAL STATUS** Independent 11 Minimal Assistance 7 Moderate Assistance 5 Considerable Assistance 3 Totally Dependent 1							
9. **BEHAVIOR** Independent 11 Minimal Assistance 7 Moderate Assistance 5 Considerable Assistance 3 Totally Dependent 1							
TOTAL RATING							
Initials							

CLIENT NAME:_____ FILE NUMBER:

Nurse Case Manager Signature/Initials

CDC CLASSIFICATION SYSTEM FOR HIV IN CHILDREN UNDER 13 YEARS OF AGE

Clients' Name:	ID #:

I. Diagnosis Classification of HIV Infection--Using the diagnosis classification definitions on the reverse side of this form, check (x) one box below.

	HIV Infected		Perinatally Exposed(Prefix E)		Seroreverter (SR)

II. Immunologic Category Definitions--Based on the CD4 count and/or percentage, determine the **immunologic category** (e.g., "1", "2", or "3").

IMMUNOLOGIC CATEGORY*	AGE OF CHILD					
	< 12 months		1-5 years		6-12 years	
	µL	(%)	µL	(%)	µL	(%)
1: No evidence of suppression	≥1,500	(≥25)	≥1,000	(≥25)	≥500	(≥25)
2: Evidence of moderate suppression	750-1,499	(15-24)	500-999	(15-24)	200-499	(15-24)
3: Severe suppression	<750	(<15)	<500	(<15)	<200	(<15)

* If the CD4+ count and the CD4+ percent indicate different classification categories, the child should be classified into the more severe category.

III. Pediatric Classification of HIV Infection--Using the attached *Clinical Category* definitions, determine and *circle one* clinical category below. *Add Prefix E* for perinatally exposed children until their HIV status is confirmed (e.g., $A1^{E}$).

	Clinical Categories (Circle One)			**(See attachment)**
Immunologic Categories (see chart above)	N: No Signs/ Symptoms	A: Mild Signs/ Symptoms	B: Moderate Signs/ Symptoms	C: Severe Signs/ Symptoms
1: No evidence of suppression	N1	A1	B1	C1
2: Evidence of moderate suppression	N2	A2	B2	C2
3: Severe suppression	N3	A3	B3	C3

I accept full professional responsibility for this client's care. This client is stable and appropriate for home care. I will work closely with the AIDS R.N. Case Manager in meeting this clients' needs in the most appropriate manner possible.

I certify that this client requires care at the nursing facility level of care or higher.

❑ **Yes** ❑ **No**

Attending Physician Signature:_____

Print Name:_____ Date:_____

(See Reverse Side)

DIAGNOSIS CLASSIFICATION OF HIV INFECTION - DIAGNOSIS DEFINITIONS

Diagnosis: HIV Infected

1. A child less than 18 months of age who is known to be HIV seropositive or born to HIV-infected mother and:
   a. has positive results on two separate determinations (excluding cord blood) from one or more of the following HIV detection tests: (1) HIV culture, (2) HIV polymerase chain reaction, and (3) HIV antigen (p24);
   or
   b. meets criteria for AIDS diagnosis on the 1987 AIDS surveillance case definition (10).

Or

2. A child at least 18 months of age or under 13 years of age born to an HIV-infected mother or any child infected by blood, blood products, or other known modes of transmission (e.g., sex contact) who:
   a. is HIV anti-body positive by repeatedly reactive enzyme immunoassay (EIA) and confirmatory test (e.g., Western blot or immunofluorescence assay (IFA)
   or
   b. meets any of the criteria in "1.a." above.

Diagnosis: Perinatally Exposed (Prefix E)--A child who does not meet the **HIV Infected Diagnosis** criteria who:

1. is HIV seropositive by EIA and confirmatory test (e.g., Western blot or IFA) and is less than 18 months of age at the time of test;

Or

2. has unknown antibody status, but was born to a mother known to be infected with HIV.

Diagnosis: Seroreverter (SR)--A child who is born to an HIV-infected mother and who:

1. has been documented as HIV-antibody negative (i.e., two or more negative AC tests performed at 8-18 months of age or one negative EIA test after 18 months of age);

and

2. has had no other laboratory evidence of infection (has not had two positive viral detection tests, if performed);

and

3. has not had an AIDS-defining condition.

CDC CLASSIFICATION SYSTEM FOR HIV IN CHILDREN UNDER 13 YEARS OF AGE (Continued)

CLINICAL CATEGORIES

Category N: Not Symptomatic--Children who have no signs or symptoms considered to be the result of HIV infection or who have only one of the conditions listed in Category A.

Category A: Mildly Symptomatic--Children with two or more of the conditions listed below but none of the conditions listed in Categories B and C.
* Lymphadenopathy (≥ 0.5 cm at more than two sites: bilateral = one site) * Hepatomegaly * Splenomegaly * Dermatitis * Parotitis * Recurrent or persistent upper respiratory infection, sinusitis, or otitis media

Category B: Moderately Symptomatic--Children who have symptomatic conditions other than those listed for Category A or C that are attributed to HIV infection. Examples of conditions in clinical Category B include but are not limited to:
* Anemia (<8 gm/dL), neutropenia (<1,000/mm^3), or thrombocytopenia (<100,000/mm^3) persisting ≥ 30 days
* Bacterial meningitis, pneumonia, or sepsis (single episode) * Candidiasis, oropharyngeal (thrush), persisting (> 2 months) in children > 6 months of age * Diarrhea, recurrent or chronic * Hepatitis
* Herpes simplex virus (HSV) stomatitis, recurrent (more than two episodes within 1 year) * Leiomyosarcoma
* Lymphoid interstitial pneumonia (LIP) or pulmonary lymphoid hyperplasia complex * Nephropathy *Nocardiosis
* Persistent fever (lasting > 1 month) * Toxoplasmosis, onset before 1 month of age
* Varicella, disseminated (complicated chickenpox)

Category C: Severely Symptomatic--Children who have any condition listed in the 1987 surveillance case definition for Acquired Immunodeficiency Syndrome, with the exception of LIP. Severe conditions included in clinical Category C for children infected with HIV:
* Serious bacterial infections, multiple or recurrent (i.e., any combination of at least two culture-confirmed infections within a 2-year period), of the following types: septicemia, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media, superficial skin or mucosal abscesses, and indwelling catheter-related infections)
* Candidiasis, esophageal or pulmonary (bronchi, trachea, lungs) * Coccidioidomycosis, disseminated (at site other than or in addition to lungs or cervical or hilar lymph nodes) * Cryptococcsis, extrapulmonary persisting > than 1 month * Cryptosporidiosis or isosporiasis with diarrhea * Cytomegalovirus disease with onset of symptoms at age > 1 month (at a site other than liver, spleen, or lymph nodes) * Encephalopathy (at least one of the following progressive findings present for at least 2 months in the absence of a concurrent illness other than HIV infection that could explain the findings): a) failure to attain or loss of developmental milestones or loss of intellectual ability, verified by standard developmental scale or neuropsychological tests; b) impaired brain growth or acquired microcephaly demonstrated by head circumference measurements or brain atrophy demonstrated by computerized tomography or magnetic resonance imagining (serial imagining is required for children < 2 years of age); c) acquired symmetric motor deficit manifested by two or more of the following: paresis, pathologic reflexes, ataxia, or gait disturbance * Herpes simplex virus infection causing a mucocutaneous ulcer that persists for > 1 month; or bronchitis, pneumonitis,or esophagitis for any duration affecting a child > 1 month of age
* Histoplasmosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes)
* Kaposi's sarcoma * Lymphoma, primary, in brain * Lymphoma, small, noncleaved cell (Burkitt's), or mmunoblastic or large cell lymphoma of B-cell or unknown immunologic phenotype * Mycobacterium tuberculosis, disseminated or extrapulmonary * Mycobacterium, other species or unidentified species, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes) * Pneumocystis carinii pneumonia * Salmonella nontyphoid) septicemia, recurrent * Toxoplasmosis of the brain with onset at > 1 month of age * Wasting syndron following findings: a)persistent weight loss > 10% of baseline OR b) downward crossing of at least two of the following percentile lines on the weight-for-age chart (e.g., 95th, 75th, 50th, 25th, 5th) in a child 1 year of age OR c) < 5th percentile on weight-for-height chart on two consecutive measurements, ≥30 days apart PLUS a) chronic diarrhea (i.e., at least two loose stools per day for 30 days OR b) documented fever (for ≥ 30 days, intermittent or constant)

e.___ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

   a. X Yes b.__ No

7. A waiver of §1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

   a.___Yes b. X No c.___ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

   a. X Yes b.___ No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

   a. X Yes b.___ No

   If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify): Alameda, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Kern, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yuba, and Yolo.

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a. X Case management

b. X Homemaker Services

c. ___ Home health aide services

d. ___ Personal care services

e. ___ Respite care

f. ___ Adult day health

g. ___ Habilitation

___ Residential habilitation

___ Day habilitation

___ Prevocational services

___ Supported employment services

___ Educational services

h. X Environmental accessibility adaptations (Minor Physical Adaptations to the Home)

i. X Skilled nursing

j. X Transportation (Limited to non-Emergency Medical Transportation)

k. X Specialized medical equipment and supplies

l. ___ Chore services

m. ___ Personal Emergency Response Systems

n. ___ Companion services

o. ___ Private duty nursing

p.___ Family training

q. X Attendant care

r.___ Adult Residential Care

___ Adult foster care

___ Assisted living

s. ___ Extended State plan services (Check all that apply):

___ Physician services

___ Home health care services

___ Physical therapy services

___ Occupational therapy services

___ Speech, hearing and language services

___ Prescribed drugs

___ Other (specify): _____

t. X Other services (specify): (1) Psychotherapy, (2) Medi-Cal Supplement for Infants and Children in Foster Care, (3) Nutritional Supplements, (4) Home Delivered Meals, and (5) Nutritional Counseling

u.___ The following services will be provided to individuals with chronic mental illness:

___ Day treatment/Partial hospitalization

___ Psychosocial rehabilitation

___ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services, which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

    a. ___ When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).

    b.___ Meals furnished as part of a program of adult day health services.

    c.___ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver that resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

    For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:

    a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

        1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and

2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P. L. 98-502.

a. X Yes b. ___ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. ___Yes b. X No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of June 1, 2004 is requested.

20. The State contact person for this request is Brigitte Baul, Chief, Demonstration Project Unit, Rate Development Branch, Department of Health Services, who can be reached by telephone at (916) 552-9631

21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature:

Print Name: Stan Rosenstein

Title: Deputy Director, Medical Care Services
California Department of Health Services

Date:

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION, CHECK ONE:

__ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

__ The waiver will be operated by _____ agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

_X_ The waiver will be operated by Office of AIDS (OA), a separate division within the Single State agency. The OA is responsible for day-to-day administration including liaison and technical assistance to providers and service sites, service reviews, monitoring of utilization, development and oversight of client eligibility standards, and investigation and resolution of provider, client, and public grievance/complaints to ensure the quality of services and the health and safety of clients. The Medi-Cal Policy Division (MCPD) within the Single State Agency is liaison with the Centers for Medicare and Medicaid Services (CMS) and, in collaboration with the OA, submits correspondence, reports, independent assessments, waiver amendments, and waiver renewal applications to CMS. The OA and MCPD work collaboratively to administer the federally approved waiver, develop policies, protocols, and procedures consistent with the waiver, and prepare waiver amendments and renewals. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver.

Per State guidelines, the local Waiver agencies conduct a medical record review annually. At a minimum, the local Waiver agencies include the State-required indicators in this review. Results of this review, along with the Corrective Action Plan (CAP) for noted deficiencies, are communicated to the State on the State-required Semi-Annual Progress Reports. A program evaluation is conducted once each 18 months for all waiver agencies/case management agencies and may include a site visit; a review of the accounting system, client case records and policies and procedures; and an evaluation of the agency's compliance with program requirements. Specific areas that will be evaluated for documentation include eligibility; level of care; service plan and outcomes; client choice; and client receipt of the agency's grievance procedure. The agency's quality assurance plan and activities and verification of caregiver qualifications will also be reviewed. For clients who have transferred between the AIDS Case Management and AIDS Medi-Cal Waiver programs, file documentation will be reviewed for clarity regarding transfer dates, client agreement and understanding of programmatic differences. After completion of the program evaluation, a written report identifying any areas requiring corrective action will be provided. Corrective action items are monitored by OA staff until compliance is achieved.

Compliance with program requirements is also assured through provision of technical assistance on an ongoing basis. This is accomplished through periodic site visits to discuss program issues, participation in client case conferences, telephone contact, correspondence, policy directives and all project meetings and workshops.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/ standards for each service are set forth in Appendix B-2.

a. X Case Management

X Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. X Yes 2. ___No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1. X Yes 2. ___No

__ Other Service Definition (Specify):

b. X Homemaker:

X Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

X Other Service Definition (Specify): Services provided are in addition to, not in place of, services authorized under the State Plan IHSS/PCSP Program. The case manager will determine when the client requires more hours of care than the number of hours authorized by IHSS for that client.

c. ___ Home Health Aide Services:

___ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

___ Other Service Definition (Specify):_____

d.___ Personal care services:

___ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed-making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

___ Payment will not be made for personal care services furnished by a member of the individual's family.

___ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

___ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

___ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

___ A registered nurse, licensed to practice nursing in the State.

___ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

___ Case managers

___ Other (Specify): _____

3. Frequency or intensity of supervision (Check one):

___ As indicated in the plan of care

___ Other (Specify): _____

4. Relationship to State plan services (Check one):

___ Personal care services are not provided under the approved State plan.

___ Personal care services are included in the State plan, but with limitations. The waivered service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

___ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

___ Other service definition (Specify):

e. ___ Respite care:

___ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

____ Other service definition (Specify):

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

___ Individual's home or place of residence

___ Foster home

___ Medicaid certified Hospital

___ Medicaid certified NF

___ Medicaid certified ICF/MR

___ Group home

___ Licensed respite care facility

___ Other community care residential facility approved by the State that it's not a private residence (Specify type): _____

___ Other service definition (Specify): _____

f. ____ Adult day health:

___ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1. ___ Yes 2. ___ No

___ Other service definition (Specify): _____

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. ___ Habilitation:

___ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

___ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision that would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation that shows that Medicaid payment does not cover these components is attached to Appendix G.

___ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

___ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

___ Individuals will not be compensated for prevocational services.

___ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or Public Law 94-142; and

2. The individual has been de-institutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

___ Educational services, which consist of special education and related services as defined in section s (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or Public Law 94-142; and

2. The individual has been de-institutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

___ Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or Public Law 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or Public Law 94-142; and

2. The individual has been de-institutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1. ___ Yes 2. ___ No

___ Other service definition (Specify): __

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. X Environmental accessibility adaptations: (Minor Physical Adaptations to the Home)

X Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

X Other service definition (Specify): If the service requires local building permits, then the agency must be licensed. For jobs of smaller scope the provider staff should check references to ensure the legitimacy of the service provider. Reference check information and the type of services provided should be documented in the service plan. Minor Physical Adaptations to the Home combined with Specialized Medical Equipment and Supplies are not to exceed $1,000 per client per calendar year.

i. X Skilled nursing:

X Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

X Other service definition (Specify): The provision of this service will prevent institutionalization. Licensure and certification standards for the providers of skilled nursing services are included in Appendix B-2.

j. X Transportation (Non-Emergency Medical Transportation):

X Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

X Other service definition (Specify): Includes non-emergency medical transportation to health and social service providers (e.g., infusion therapy, counseling, support groups, methadone treatment, etc.) stipulated in the client's plan of care when the client does not have the means for transportation or their mobility is limited. Privately owned vehicles may be used when the case manager determines the client is capable of travel by private vehicle and when a commercial vehicle is not available or is more expensive. Use of taxi/shuttle vouchers and reimbursement of gas and automobile usage (not to exceed 34 cents per mile to licensed driver) is also permissible. This service is subject to a $40 monthly cap per client.

k. X Specialized Medical Equipment and Supplies:

X Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items that are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

X Other service definition (Specify): This service is necessary to prevent institutionalization and must be immediately needed for the client's care and safety. Purchase authorization will be granted only when the waiver agency has indicated and documented good faith efforts of their attempt to obtain provision of specialized medical equipment and supplies through the State Plan. The waiver agency must also document and justify need for the item(s) in the client's service record. Specialized Medical Equipment and Supplies combined with Minor Physical Adaptations to the Home are not to exceed $1,000 per client per calendar year. Provider qualifications are included in Appendix B-2.

L.__ Chore services:

__ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

__ Other service definition (Specify):_____

m. __ Personal Emergency Response Systems (PERS)

__ PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

__ Other service definition (Specify): _____

n. __ Adult companion services:

__ Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

__ Other service definition (Specify): _____

o. __ Private duty nursing:

___ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

___ Other service definition (Specify):___

p. __ Family training:

__ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the client's who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

__ Other service definition (Specify): ____

q. X Attendant care services:

X Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

X Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

__Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

__ Other supervisory arrangements (Specify):

__ Other service definition (Specify): _____

r. __ Adult Residential Care (Check all that apply):

__ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

___ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. This requirement does not apply where it conflicts with fire code. Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

___ Home health care

___ Physical therapy

___ Occupational therapy

___ Speech therapy

___ Medication administration

___ Intermittent skilled nursing services

___ Transportation specified in the plan of care

___ Periodic nursing evaluations

___ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

__ Other service definition (Specify):_____

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. X Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify): (1) Psychotherapy, (2) Medi-Cal Supplement for Infants and Children in Foster Care, (3) Nutritional Supplements, (4) Home Delivered Meals, and (5) Nutritional Counseling. The qualifications for the providers of each listed "other" service are found in Appendix B-2. The cost effectiveness of each service is demonstrated in Appendix G. The description of each of these services follows this paragraph.

PSYCHOTHERAPY

Psychotherapy is a service in which appropriate assessments are made by a qualified individual who provides therapy with regard to the psychological adjustment to living with HIV/AIDS. Services may also include information and referral, as well as group and family counseling with the client.

MEDI-CAL SUPPLEMENTS FOR INFANTS AND CHILDREN IN FOSTER CARE

This supplement is intended to reimburse foster parents for additional supervision, care, and expenses that may be required depending on the condition of the HIV/AIDS child. This may include intensive physical care in compliance with any special training given to them or arranged by the case manager, frequent medical/nursing care and counseling, and provision of treatments or medications in accordance with the plan of care. The foster parent will need to take special infection control measures and purchase special health care supplies not covered under Medi-Cal. Room and board, of course, shall be explicitly excluded as a cost of this foster care supplement.

The supplement is also intended to facilitate placement efforts for this difficult-to-place HIV/AIDS population. Foster care homes are not available to HIV/AIDS children without this added service incentive. The HIV/AIDS child is sometimes difficult to place because of people's fears of contamination, the social stigma that has been attached to HIV/AIDS and because HIV/AIDS children may be very sick and dying. Not many foster parents want to take on the additional emotional burden of caring for a child who will probably die. With appropriate education, counseling and other services, the addition of a foster child supplement may result in more foster care homes becoming available. The foster home must be approved and licensed according to State law and regulation. The case manager will be responsible for obtaining documentation substantiating the licensure of the foster home. The Office of AIDS staff will be responsible for verifying the licensure documentation during on-site monitoring and audit activities of the agencies.

This service will be paid for under a monthly cap of $338 per client.

NUTRITIONAL SUPPLEMENTS

Maintaining the nutritional status of the client is of critical importance and is made more difficult by many of the AIDS infections that affect the ability to chew and swallow and to absorb nutrients from the gastrointestinal tract. Both medications and the disease process produce symptoms such as pain, nausea, loss of appetite, wasting, malnutrition, dehydration, vomiting, gas or bloating, and diarrhea that become barriers to maintaining nutritional status. This Waiver service

provides additional choices to augment the normal resources for purchasing, preparing, and assisting in ensuring adequate nutritional intake that meets the needs of the client. The clinical course of HIV disease may include weight loss and muscle wasting and many infections affecting the GI system prevent adequate absorption of food and make nutritional supplements necessary. Without daily in-home help client's may need supplements to meet their nutritional needs and identification of the need for nutritional supplements will be dependent upon care plan requirements. The provision of nutritional supplements is necessary to prevent institutionalization. This service, however, is not intended to provide a full nutritional regimen (three meals a day). Nutritional Supplements combined with Home Delivered Meals will not exceed $150 per client per month. Nutritional Supplements are reimbursed at actual cost.

HOME DELIVERED MEALS

Home delivered meal services will be provided for clients who are homebound, unable to prepare their own meals and have no caretaker at home to prepare meals for them. Services may be provided daily, and will not exceed the requirement for normal nutritional intake. The number and frequency of meals per day will be dependent upon care plan requirements. Home Delivered Meals combined with Nutritional Supplements will not exceed $150 per client per month. Home Delivered meals are reimbursed for at actual cost. This service will be provided to supplement nutrition and is necessary to prevent institutionalization. The provision of meals is not intended to provide a full nutritional regimen (three meals a day).

In rural areas where a "meals on wheels" vendor may be unavailable, the home delivered meal may be provided by an individual. In these incidences the above criteria regarding the client's condition must be met. In addition, the following must be documented in the client's care plan: (1) there is no vendor available or no vendor who will deliver services to the clients' home; (2) the amount being reimbursed for food and preparation cost is based on "usual and customary fees" charged by "meals on wheels" vendors, and (3) a copy of the written agreement that outlines the details between the waiver agency and the individual providing this service.

NUTRITIONAL COUNSELING

This service will provide clients and their caregivers with guidance on the promotion of eating habits and food choices that maximize nutritional opportunities for the client who is faced with disease symptoms such as nausea or diarrhea, and prevent potential drug/food interactions. Food choices can be planned to meet ethnic and personal choices and financial constraints while promoting nutritional goals. This service will be provided by a registered dietician who has indicated by agreement with the agency to provide nutritional counseling services on a consultant basis. Services will be paid for based on an hourly rate and the frequency and need for services will be determined by the case manager.

t. ___ Extended State plans services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

__ Physician services

__ Home health care services

__ Physical therapy services

__ Occupational therapy services

__ Speech, hearing and language services

__ Prescribed drugs

__ Other State plan services (Specify): _____

u. ___ Services for individuals with chronic mental illness, consisting of (Check one):

__ Day treatment or other partial hospitalization services check one):

__ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or

other mental health professionals to the extent authorized under State law),

b. occupational therapy, requiring the skills of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

d. drugs and biologicals furnished for therapeutic purposes,

e. individual activity therapies that are not primarily recreational or diversionary,

f. family counseling (the primary purpose of which is treatment of the individual's condition),

g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

__ Other service definition (Specify): _____

___ Psychosocial rehabilitation services (Check one):

___ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

b. social skills training in appropriate use of community services;

c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and

d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

a. vocational services,

b. prevocational services,

c. supported employment services, and

d. room and board.

__ Other service definition (Specify): _____

__ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

__ This service is furnished only on the premises of a clinic.

__ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify): _____

APPENDIX B-2, PROVIDER QUALIFICATIONS, A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administration Code, and other standards are referenced by citation.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
1 Case Management	RN and MSW or MFCC or Clinical Psychologist or LCSW or similar qualifications	BP--Ch.6, Art.2, Sec. 2732; Ch.13, Art.1, Sec. 4980 (b)		Title 22, Sec. 51147, MSW from Accredited School of Social Work
2 Skilled Nursing	RN or LVN	BP--Ch.6, Art.2, Sec. 2732; Div. 2, Ch.6.5, Art.1, Secs 2872 & 2873		
3 Attendant Care	CHHA or CNA		HS Sections 1337.3, 1337.6	Title 22, Sec.74709 (under RN or LVN supervision) APDL98-25& Policy Statement 98-02
4 Homemaker Services	Trained Individual			Basic orientation on HIV/AIDS and its affect on the immuno-suppressed client, basic infection control, and confidentiality
5 Psychotherapy	LCSW, ACSW (supervised by LCSW) Psychologist, MFCC, MFT, psychiatric and mental health CNS/NP	BP—Ch 6., Art. 9, Sec. 2838, Ch.14, Art.4, Sec. 4996; Ch.13, Art.1, Sec. 4980(b); Ch.13, Art.5, Sec. 4986, NPA, Article 8		
6 Minor Physical Adaptations to the Home)	Building Contractor	Contractor License Business License		Reference check Local building permits
7 Medi-Cal Supplement for Infants and Children in Foster Care	Foster Parent		WI, Section 16525.13	
8 Nutritional Supplements	Pharmacy or NS vendor	Appropriate Local Vendor License		
9 Home Delivered Meals	Meets Local Meals on Wheels Vendor Qualifications	Appropriate Local Vendor License		
10 Nutritional Counseling	Registered Dietician			American Dietetic Association RD accreditation
11 Specialized Medical Equipment and Supplies	Local Medical Supply Vendor	Business License		
12 Non-Emergency Medical Transportation	Public Carriers or Private individual	Business License for Public Carrier		

ACSW = Associate Clinical Social Worker
BP = Business & Professions Code
CHHA= Certified Home Health Aide
CNA = Certified Nurses Assistant
CNS = Clinical Nurse Specialist
HS = Health and Safety Code
LCSW= Licensed Clinical Social Worker
LVN = Licensed Vocational Nurse
MFCC= Marriage, Family, Child Counselor
MSW = Master's Degree in Social Work
MFT = Marriage and Family Therapist
NP = Nurse Practitioner
NPA = Nurses Practices Act
NS = Nutritional Supplement Vendor
RN = Registered Nurse
WI = Welfare & Institutions Code

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

___ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

_X_ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency. Copies of State community care licensing regulations, listed below, have been provided as a separate package.

Type	Source Reference
Adult Residential Facilities	Title 22, Division 6, Chapter 6
Foster Family Homes	Title 22, Division 6, Chapter 7.5
Small Family Homes	Title 22, Division 6, Chapter 4
Residential Care Facilities for the Chronically Ill	Title 22, Division 6, Chapter 8.5
General Licensing Requirements	Title 22, Division 6, Chapter 1

SECTION 1915(c) WAIVER FORMAT

APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. (Check all that apply.)

1. X Low-income families with children as described in section 1931 of the Social Security Act.

2. X SSI recipients (SSI Criteria States and 1634 States).

3. __ Aged, blind or disabled in 209(b) States who are eligible under 42 CFR 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4. X Optional State supplement recipients

5. X Optional categorically needy aged and disabled who have income at (Check one):

   a. X 100% of the Federal poverty level (FPL) plus additional income disregards approved in the State Plan.

   b. __ ___ Percent of FPL which is lower than 100%.

6. __ The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

   Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

   ___ A. Yes ___ B. No

Check one:

a. __ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. __ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) __ A special income level equal to:

___ 300% of the SSI Federal benefit (FBR)

___ ____% of FBR, which is lower than 300%(42CFR 435.236)

___ $___ which is lower than 300%

(2) __ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3) __ Medically needy without spend down in States that also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4) __ Medically needy without spend down in 209(b) States. (42 CFR 435.330)

(5) __ Aged and disabled who have income at:

a. __ 100% of the FPL

b. __ ___% which is lower than 100%.

(6) __ Other (Include statutory reference only to reflect additional groups included under the State plan.) _____

7. X Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330).

8. Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

Appendix C-2--Post-Eligibility

REGULAR POST ELIGIBILITY

1. X **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. **§435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

1. Allowances for the needs of the

a. Individual:: (Check one):

(1) X The following standard included under the State plan (check one):

(a)___ SSI
(b)___ Medically needy
(c)___ The special income level for the institutionalized
(d)___ The following percent of the Federal poverty level):____%
(e) X Other (specify): An amount which represents the sum of (1) the income standard used to determine eligibility/share of cost and (2) any amounts of income disregarded during the section 1902(a)(10)(A)(ii)(vi) eligibility phase.

(2). __ The following dollar amount: $_____*
*If this amount changes, this item will be revised.

(3). __ The following formula is used to determine the needs allowance:
_____

Note: If the amount protected for waiver recipients in item 1. is equal to, or greater than the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, enter NA in items 2. and 3. following.

b. Spouse only (check one):

(1)__ SSI standard

(2)__ Optional State supplement standard

(3)__Medically needy income standard

(4)__ The following dollar amount: $_____* *If this amount changes, this

item will be revised.

(5)__ The following percentage of the following standard that is not greater than the standards above: __% of ____ standard.

(6)__ The amount is determined using the following formula:

(7) X Not applicable (N/A)

c. Family (check one):

(1) __ AFDC need standard

(2) __ Medically needy income standard
The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

(3) __ The following dollar amount: $ _____ *
*If this amount changes, this item will be revised.

(4) __ The following percentage of the following standard that is not greater than the standards above: ___+% of ____ standard.

(5) __ The amount is determined using the following formula: _____

(6) __ Other

(7) X Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.b. ___ **209(b) State,** a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. **42 CFR 435.735**--States using more restrictive requirements than SSI.

1. Allowances for the needs of the

a. individual: (check one):

(1)__ The following standard included under the State plan (check one):

(a)__ SSI

(b)__ Medically needy

(c)__ The special income level for the institutionalized

(d)__ The following percentage of the Federal poverty level: _____ %

(e)__ Other (specify): _____

(2)__ The following dollar amount: $_____*
* If this amount changes, this item will be revised.

(3)__ The following formula is used to determine the amount: _____

Note: If the amount protected for waiver recipients in 1. is equal to, or greater than the maximum amount of income a waiver recipient may have and be eligible under §435.217, enter NA in items 2. and 3. following.

b. spouse only (check one):

(1) __ The following standard under 42 CFR 435.121:_____
_____

(2) __ The medically needy income standard _____;

(3) __ The following dollar amount: $_____*
*If this amount changes, this item will be revised.

(4) __ The following percentage of the following standard that is not greater than the standards above: _____% of _____.

(5) __ The following formula is used to determine the amount:

(6) __ Not applicable (N/A)

c. family (check one):

(1) __ AFDC need standard

(2) __ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

(3) __ The following dollar amount: $_____*
*If this amount changes, this item will be revised.

(4) __ The following percentage of the following standard that is not greater that the standards above: ___% of ___ standard.

(5) __ The following formula is used to determine the amount:

(6) __ Other

(7) __ Not applicable (N/A)

2. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2.__ The State uses the post-eligibility rules of 1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution towards the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

A. Allowance for personal needs of the individual: (check one)

1.___ SSI Standard

2. ___ Medically Needy Standard

3. ___ The special income level for the institutionalized

4. ___ The following percent of the Federal poverty level:_____%

5. ___ The following dollar amount $_____**

**If this amount changes, this item will be revised.

6.___ The following formula is used to determine the needs allowance:
_____

7.___ Other (specify):
_____
_____

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.
_____
_____

APPENDIX D, ENTRANCE PROCEDURES AND REQUIREMENTS
APPENDIX D-1

a. **EVALUATION OF LEVEL OF CARE**

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services. The initial level of care evaluation is conducted by the nurse case manager (RN licensed by the State).

Client's considered for potential enrollment in the HIV/AIDS Waiver are referred from various sources including: case management programs, hospital discharge planners, attending physicians, community agencies, governmental agencies, family members, relatives, friends, and self-referral. Each agency will perform outreach activities to potential referral sources, including agencies serving homeless clients, in its service area to provide information regarding the AIDS Medi-Cal Waiver Program.

The screening process is initiated when the case manager receives a referral from any source. The case manager then makes sure that the client is a Medi-Cal recipient prior to enrollment in the program and that there are no third party sources of payment for the same services. The case managers then obtains the medical and social history, current medical condition, psychosocial status needs. During this initial screening, referrals to other agencies or programs may be made, depending on the client's needs.

In order for the client to continue to be eligible in the Waiver program his/her level of care must meet the Nursing Facility eligibility criteria (see page 3), in conjunction with a rating of 60 or less on the Cognitive and Functional Ability Scale (see pages 4-6) or the CDC Classification System for HIV in Children Under 13 Years of Age (see pages 7-9). The Cognitive and Functional Ability Scale is based on the Karnofsky Performance Status Scale. Within this scale, a client's condition can be rated on a scale from 100 to 0, from normal health to dead. Spaced in increments of 10 points each, one sentence descriptions define certain levels of the client's health status during a progressively fatal disease. At 60 on this scale, a client has been identified as early chronic, is unable to carry on normal activity or to do active work, requires occasional assistance, but is able to care for most of his/her care needs. The Cognitive and Functional Ability Scale is a tool which was developed to adapt the Karnofsky Performance Status Scale to be more specific to HIV/AIDS related needs as the scale will be used in the California Waiver program, nurse case managers will assess a client's condition using the general outline of the scale.

In an effort to recognize the differences of HIV infection in adults and children, CDC currently recognizes three clinical categories of pediatric HIV infection. Category A: Mildly Symptomatic includes infants and children with two or more conditions listed in Category A but none of the conditions listed in Categories B and C. Category B:

Moderately Symptomatic includes infants and children who have symptomatic conditions other than those listed for Category A or C that are attributed to HIV infection. Category C: Severely Symptomatic includes infants and children who have any conditions listed in the 1987 surveillance case definition for acquired immuno-deficiency syndrome, with the exception of Lymphoid interstitial pneumonia.

The client's level of care and service needs will be closely monitored by the nurse case manager. Due to the nature of the illness, levels of care may change rapidly. If the level of care temporarily drops, the client will receive no waiver services as long as their level of care is less than Nursing Facility. The case manager will assist the client in obtaining needed services from other resources (e.g., federal Ryan White, State AIDS Case Management Program, etc.) during this period. Client's, who have received waiver services however, may be readmitted to the program when they again meet at least the NF level of care and all other criteria.

b. **QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION**

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

___ Discharge planning team

___ Physician (M.D. or D.O.) (Certification)

_X_ Registered Nurse, licensed in the State

___ Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

___ Other (Specify): _____

APPENDIX D-2

a. **REEVALUATIONS OF LEVEL OF CARE**

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

___ Every 3 months
___ Every 6 months
___ Every 12 months
_X_ Other (Specify):

Level of care reevaluations (both Cognitive and Functional Ability for adults or pediatric for children and Nursing Facility) will be conducted at least every 60 days. In order for the client to continue to be eligible in the waiver program, his/her level of care must meet the eligibility criteria. A case manager maintains ongoing contact with the client, family, and service providers to ensure that services are appropriate and are meeting the client's needs as designed in the service plan. This may include face-to-face or telephone contact with the client and with the client's direct care providers. In addition, periodic case conferences are held between the case manager and the client's direct care providers to discuss the clinical and psycho-social care needs of the client.

During the initial assessment and ongoing contacts the case managers discuss the service plan with the client and/or his/her legal representative. Input is incorporated into the core case management team's discussion regarding the plan. The core case management team will meet at least every 60 days to discuss the needs of the client and to reevaluate and update the service plan. Significant findings of the core case management assessments and evaluations shall be appropriately documented in the service record. The case managers will approve and sign the updated service plan.

To ensure level of care evaluations are conducted timely, Office of AIDS will review them during routine monitoring and auditing activities. Monitoring and auditing activities will be conducted once each 18 months and episodically where necessary. The factors used, as a guide to determine the level of care needs of the adult are specified on page 3 entitled Nursing Facility (NF) Level of Care.

b. **QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS**

Check one:

_X_ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

___ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

___ Physician (M.D. or D.O.)
___ Registered Nurse, licensed in the State
___ Licensed Social Worker
___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)
___ Other (Specify):

c. **PROCEDURES TO ENSURE TIMELY REEVALUATIONS**

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

___ "Tickler" file

___ Edits in computer system

_X_ Component part of case management

___ Other (Specify): _____

APPENDIX D-3

a. **MAINTENANCE OF RECORDS**

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):
   ___ By the Medicaid agency in its central office
   ___ By the Medicaid agency in district/local offices
   ___ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program
   _X_ By the case managers
   _X_ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations
   ___ By service providers
   ___ Other (Specify): _____

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. **COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT**

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix. For the initial evaluation and reevaluations, the determination of the level of care will be based on eligibility for the Nursing Facility level of care or higher (see page 3). In addition, at time of initial evaluation and each reevaluation, the clients' functional status is assessed utilizing the *Cognitive and Functional Ability Scale* for Adult clients (see pages 4-6) or *the CDC Classification System for Children Under 13 Years of Age* for pediatric clients (see pages 7-9).

For persons diverted rather than de-institutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

_X_ The process for evaluating and screening diverted individuals is the same as that used for de-institutionalized persons.

___ The process for evaluating and screening diverted individuals differs from that used for de-institutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

APPENDIX D-4

a. **FREEDOM OF CHOICE AND FAIR HEARING**

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:

   a. informed of any feasible alternatives under the waiver; and

   b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:

   a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing (see pages 55-58);

   b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver (see page 55);

   c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services (see page 55); and

   d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E (see pages 56-58).

b. **FREEDOM OF CHOICE DOCUMENTATION**

Specify where copies of this form are maintained:

Copies of these forms are kept in the client's service record. *See Agreement to Participate* (page 55), AIDS Medi-Cal Waiver Program *Notice of Action (Denial/Reduction/Termination)* (page 56), and *State Hearing Notice* (pages 57-58).

AIDS Medi-Cal Waiver Program
NOTICE OF ACTION (NOA)
DENIAL/REDUCTION/TERMINATION OF AIDS MEDI-CAL WAIVER BENEFITS

Name _____ **Date of Notice** _____

Address _____ **Medi-Cal I.D. #** _____

_____ **Waiver I.D. #** _____

Date Services Will Expire _____

Medi-Cal regulations allow for the provision of certain AIDS Medi-Cal Waiver Program (MCWP) Home and Community-Based Services (HCBS) to persons who meet specific criteria. We have taken the following action with respect to services requested: for the reasons noted:

___ 1. Denied your application or ended services for causes such as program noncompliance or personal safety of caregivers or agency staff, specifically _____.

___ 2. Denied your application or ended services because you do not meet eligibility requirements as follows:

☐ You have not submitted adequate proof of Medi-Cal eligibility, your Medi-Cal eligibility cannot be verified or you are not eligible or no longer eligible for Medi-Cal.

☐ Your medical condition and/or medical needs do not currently meet the Nursing Facility or higher level of care and/or or your diagnosis of asymptomatic HIV or AIDS does not meet eligibility requirements, or your score on the evaluation that is used (the Cognitive and Functional Ability Scale) was too low.

___ 3. Denied and/or reduced some portion of the services requested. Your medical condition and/or medical needs have improved necessitating a change in services ordered.

___ 4. Continuing to provide HCBS to you is not cost effective (i.e., the estimated cost of providing you with those services exceeds cost guidelines set by the State).

___ 5. Cost of services provided to you has reached the $13,209 calendar year annual cost cap. No more AIDS Medi-Cal Waiver services can be provided to you this calendar year.

___ 6. The services you need are fully available to you through private insurance, Medicare, Medi-Cal, or another program.

___ 7. You no longer desire HCBS.

___ 8. Other_____

This NOA is required by Code of Federal Regulations, Title 42, Chapter IV, Subpart E, and Social Security Act, Title 22, Section 51346. You have the right to ask for a State Hearing (SH) if you disagreed with any MCWP action. You only have ninety (90) days to ask for a hearing. The 90 days started the day after the MCWP gave or mailed you this notice. See page 2 for your appeal rights.

Denial or termination of AIDS MCWP benefits will not affect other medical or social services you are eligible to receive through California's Medi-Cal Program or other public benefit programs.

You may reapply for AIDS MCWP benefits at a future time if you believe you have become eligible. Please call me for further information or if you have any questions. I may be reached at (_____)_____.

Sincerely,

_____ _____
Agency Representative Agency Name

STATE HEARING NOTICE - YOUR RIGHT TO APPEAL THE "NOTICE OF ACTION"

State Hearing Instructions--If you do not agree with the action described, you may request a State Hearing before an Administrative Law Judge employed by the California Department of Social Services (CDSS). This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your case manager can help you request a hearing. If you decide to request a hearing, you must do so within 90 days of the date of this notice. Your benefits will only continue until the *Services Expiration Date* listed at the top of page 1 which is at least 10 days from the date of this notice. If you are currently receiving AIDS MCWP services and you request a SH before the **Date Services Expire** indicated at the top of this notice (at least10 days after the date of this notice), you will continue to receive services until a SH decision is made. If you are currently receiving AIDS MCWP services and you request a SH after the **Date Services Expire**, your AIDS MCWP services will stop on the **Date Services Expire**. You must verbally notify your case manager if you file an appeal within this 10-day period.

If you wish to request a State Hearing, please complete the attached *Request for a State Hearing* form and mail it to the address listed below or call the phone number provided. You must provide all the information on the form; any information missing from the request form may delay the processing of your State Hearing request. If you ask for a hearing the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the AIDS provider's written position on your case at least two days before the hearing. The SHD may give your hearing file to the California Department of Health Services and the United States Department of Health and Human Services per Welfare and Institutions Code Sections 10850 and 10950.

How to Request a State Hearing—You must either complete the attached *Request for a State Hearing* **form and mail it to:**

California Department of Social Services
State Hearing Division
P.O. Box 944243
Sacramento, CA 94244-2430

Or call

Toll-Free Number: (800) 952-5253
Teletypewriter (TTY only: (800) 952-8349

"Your Rights" Pamphlet Available--"Your Rights under California Welfare Programs pamphlet" issued by CDSS, provides useful information about State hearings. This pamphlet will be sent to you when your hearing request is processed.

Authorized Representative--You can represent yourself at the State Hearing or be represented by a friend, attorney, or any other person; but, you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of the Public Inquiry and Response Unit (PIAR) at (800) 952-5253.

The PIAR can also provide further information about your hearing rights. Assistance is available in languages other than English, including Spanish.

Code of Federal Regulations, Title 42,Section 431.220, Subpart E, Chapter IV, and Social Security Act, Title 22, Section 51014.1, require that this **Notice of Action/State Hearing Notice** be mailed at time of denial of an application when it is determined that you are not eligible for waiver services or at time of reduction or termination of existing services. The Notice must be mailed **at least 10 calendar days** (excluding the mailing date) before the effective date of reduction or termination of services.

REQUEST FOR A STATE HEARING

Name	**Medi-Cal I.D. Number**
Address	**City**

I am requesting a State Hearing because of Medi-Cal related action by _____, an AIDS Medi-Cal Waiver agency related to the following reason(s):

___ Denial of my application or ending of services for causes such as noncompliance or personal safety of caregivers or agency staff **OR**

___ Denial of my application or ending of services because I do not meet eligibility requirements **OR**

___ Denial and/or reduction of some portion of the service(s) requested **OR**

___ Ending of services because it is no longer cost effective to do so or the costs of services provided have reached the $13,209 calendar year annual cost cap.

___ Denial of my application or ending of services because services I need are fully available through private insurance, Medicare, Medi-Cal, or another program or I no longer desire Home and Community Based services.

___ Other_____

Describe the basis for your appeal below:

_____

_____

_____

___ I speak a language other than English and need an interpreter for my hearing. (The State will provide the interpreter at no cost to you.)

Language:	Dialect:

___ I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)

Name: _____ Phone Number:_____

Street Address:

_____

City:_____State_____Zip Code_____

Signature: Date:

Mail to: California Department of Social Services
State Hearing Division
P.O. Box 944243
Sacramento, CA 94244-2430
Toll-Free Number: (800) 952-5253
Teletypewriter (TTY) only: (800) 952-8349

The AIDS Medi-Cal Waiver Program is administered by the Community Based Care Section, Office of AIDS, Department of Health Services, 611 N. Seventh Street, P.O. Box 942732, Sacramento, CA 94234-7320, (916) 445-0553.

MCWP2 (rev 12-2000)

AIDS MEDI-CAL WAIVER PROGRAM (MCWP)
INFORMED CONSENT, AGREEMENT TO PARTICIPATE MCWP 1 (rev. 6/00)

APPLICANT'S NAME: Medi-Cal #

I understand that as part of my application for services under the MCWP, the Nurse Case Manager must evaluate my condition. My Nurse Case Manager will coordinate the care I receive at home. If I am eligible and choose to participate, I understand that:

1. I will participate in the process for deciding the services that I will receive and will be notified of what services I am to receive and any subsequent changes made to these services. These services will be based on need and availability of funding and that it is cost effective to provide these services. The MCWP is constructed so that I will incur no cost as a result of my participation. However, the MCWP monies will be the last source of payment to provide services; if care is available through another entity, e.g., insurance policy, then that source will be billed before the MCWP program.
2. The Nurse Case Manager will keep track of my progress and will develop a personalized service plan. The types and quantities of services will be determined through regular meetings with me and interdisciplinary team meetings.
3. I will be asked to provide personal information about myself including name, race, gender, health, and other pertinent information. No identifying information collected will be used against me or will be released without my consent, except as allowed by law. However, summary data based on MCWP participants (*personal identifiers deleted*) may be used by researchers for research and publication. The MCWP is committed to maintaining the highest possible level of confidentiality.
4. Information from my case record will be seen only by approved staff, consultants, and service providers, who will be serving me, or as otherwise provided by law. I understand that my case may be discussed at regular Case Conferences, consisting of MCWP staff, my physician and contractors supplying direct care services to me.
5. My participation in the MCWP is entirely voluntary and I may decide to withdraw at any time and there will be no penalties or loss of other services I am entitled to. My withdrawal will not affect the availability of medical care to me at any time. Furthermore, my doctor may withdraw me from the MCWP at any time if it's in my best interest to do so.
6. I understand that I must meet all MCWP eligibility requirements, including medical needs and condition, and that if I am institutionalized I will not receive services until my discharge. I also understand that I must comply with MCWP program requirements as explained to me at enrollment.
7. I agree to cooperate fully with Agency/MCWP staff and care providers and agree to refrain from any verbal or physical hostile, abusive, or threatening behavior. I understand that failure to comply with this provision may result in termination of services.
8. I have the right to ask any questions concerning the MCWP at any time. I will be informed of any significant new information pertinent to my participation. If I have any questions concerning the MCWP program, I may contact my Nurse Case Manager or Social Worker.
9. Client Initials _____ I acknowledge that I have received a copy of forms *Notice of Action (Denial/Discontinuance)* and *Request for a State Hearing*. I understand these forms will be mailed to me if my application is denied, if I am disenrolled from the MCWP, or if I have exhausted the Agency Grievance Policy.

   Client Initials_____I acknowledge that I have received a copy of the Agency Grievance Policy

   Client initials_____I acknowledge that I have received a copy of Client Rights.

I have been informed of both the home and community-based services of the MCWP and the alternative to these services and choose to receive MCWP services.

I have read and I understand the above information concerning the program. My signature indicates my agreement to participate in the program. I will be given a copy of this consent form to refer to as needed.

All questions I have concerning the MCWP at this time have been fully answered. If I have further questions, I should contact the MCWP Staff at:_____

Applicant's Signature: Date

Agency Representative:	Date:

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

   X Registered nurse, licensed to practice in the State

   __ Licensed practical or vocational nurse, acting within the scope of practice under State law

   __ Physician (M.D. or D.O.) licensed to practice in the State

   X Social Worker (see page 39 for qualifications)

   __ Case Manager

   __ Other (specify): _____

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.
   __ At the Medicaid agency central office
   __ At the Medicaid agency county/regional offices
   __ By case managers
   __ By the agency specified in Appendix A
   __ By consumers
   X Other (specify): Copies of the plan of care will be maintained in the individual's confidential client record. Service plans will be maintained on-site at the agency and providers within the organized health care delivery system. A sample of the service plan is attached (pages 63 and 64). Waiver agencies may develop specific forms that meet State requirements and are approved by the Office of AIDS.

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

   __ Every 3 months

   __ Every 6 months

___ Every 12 months

_X_ Other (specify): The core case management team will meet at least every 60 days to discuss the needs of the client and to reevaluate and update the service plan. Significant findings of the case management assessments and evaluations shall be appropriately documented in the client service record. The case managers will approve and sign the updated service plan.

The service plan is developed as the result of a comprehensive and thorough assessment of the individual. The nurse case manager and social work case manager perform comprehensive assessment to include physical, psychosocial, nutritional, financial, environmental, and other parameters.

Ongoing service plans are developed through the provision of periodic summary evaluations of the person with HIV/AIDS including the health and psychosocial status. These reassessments may result in the following:

a. A redefinition of service needs and service goals requiring a revised service plan;
b. A confirmation that the service needs are being met and the service plan should remain in effect as written;
c. An identification of problems in the service plan that indicate a need for closer monitoring, problem solving, or advocacy.

A written service plan shall be established for every waiver individual and incorporated in the client's health records. The nurse case manager and social work case manager will be responsible for developing and documenting the service plan. Further, the case managers will meet with the client or guardian/legal representative if one has been designated, to explain the service plan so the client can have input into the services provided. Contracted agencies will make good faith efforts to maintain multiple provider subcontracts that ensure that clients have a choice of providers.

The service plan will identify problems/needs, interventions, expected outcomes in measurable terms, and short- and long-range goals. The service plan should include at a minimum the medical and other services to be provided, their frequency, duration, and the types of providers to furnish them.

The case manager will sign the initial service plan and ensure the attending physician is notified of the contents of the plan. The case manager will document contact with the physician and note in the record the date notification occurred. The physician will be involved and will continue to be responsible for the medical care of the person.

The service record for the client will contain all information consistent with standards of medical and professional practice, which permits effective professional review and necessary follow-up. Service records will be secured in locked file cabinets when not in use.

APPENDIX E-2

a. **MEDICAID AGENCY APPROVAL**

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

Initial and revised service plans are subject to review and approval by Department of Health Services, Office of AIDS during routine monitoring and auditing activities. Monitoring and auditing activities will be conducted annually and episodically, as needed. Service plan reviews will ensure the service plan includes, but is not limited to, the following elements:

1. Service Needs and Interventions

   (a). Clearly defined priority areas for needed services, and

   (b). Within each area, measurable objectives and specific action steps to be taken, methods of, and timelines for, evaluating progress.

   (c). All needs must be addressed.

2. Type/Units of Service

   Type/units of service(s) authorized, provider(s), frequency, and time (duration).

3. Timeliness of case management team review.

b. **STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE**

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

   Waiver agencies are required to use the plan of care (i.e., service plan) forms included as pages 63 and 64 in this document. Waiver agencies may also, with prior approval from the State, use an alternate form that meets State requirements.

AIDS CASE MANAGEMENT PROGRAM/AIDS MEDI-CAL WAIVER PROGRAM

COMPREHENSIVE CLIENT SERVICE PLAN

CLIENT NAME:			**CLIENT NUMBER:**			**EVALUATION**				
LONG TERM GOAL(S):						***DATE/INITIALS CODE***				
DATE	**PROBLEM/NEED**	**GOAL(S)**	**INTERVENTION(S)** ***SERVICE / QUANTITY / FREQUENCY / DURATION / TYPE OF SERVICE***	**PSC**	**START OF SERVICE**					

RN Case Manager: Signature/Initials

_____ /____

_____ /____

_____ /____

Social Worker: Signature/Initials

_____ /____

_____ /____

_____ /____

Payment Source Codes

MCWP --	W
Private/3rd party --	1
CMP --	2
Medi-Cal --	3
Medicare --	4
Multiple (see progress notes) --	5
Other -- (see progress notes) --	6
Care Title I/II --	7
HOPWA --	8

Evaluation Codes

Need Resolved, Services Discon.- -	A
Services Continued --	B
Services Continued With Changes--	C
Services Not Delivered --	D
Services Discontinued (Other) --	E

M.D. sent copy/notified of contents of initial plan Yes_____ Date_____

CMP/MCWP 10

AIDS CASE MANAGEMENT PROGRAM/AIDS MEDI-CAL WAIVER PROGRAM

COMPREHENSIVE CLIENT SERVICE PLAN

DATE	PROBLEM/NEED	GOAL(S)	INTERVENTION(S) *SERVICE / QUANTITY / FREQUENCY / DURATION / TYPE OF SERVICE*	PSC	START OF SERVICE	Evaluation Review, and/or Changes				

Client Name: _____ Client Number: _____

CMP/MCWP 10

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

   _X_ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System MMIS).

   ___ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

   ___ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

   ___ Other (Describe in detail): _____

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process (see page 66). This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

   a. When the individual was eligible for Medicaid waiver payment on the date of service;

   b. When the service was included in the approved plan of care;

c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (Public Law 94-142) or section 110 of the Rehabilitation Act of 1973.

___ Yes

_X_ No. These services are not included in this waiver.

Procedures for Organized Health Care Delivery Systems

In order to claim reimbursement, an agency which chooses to be an organized health care delivery system, must first obtain a special Medi-Cal provider number (AYD000XXX) through the State Office of AIDS. All contracts will conform to the applicable provisions of 42 CFR, part 434.

Claims for Waiver Program services are reimbursed only for persons meeting Waiver eligibility requirements who have first been enrolled with the State Office of AIDS. A Waiver agency provides the Office of AIDS with client-related information including social security number, ethnicity, level of care, etc. The Office of AIDS issues a client-specific Waiver Identification Number confirming the enrollment. The Waiver Identification Number is used by the agency when preparing claims for reimbursement under the Waiver Program. The client may have only one case management team and one service plan in operation at any one time. The Office of AIDS assures that dual enrollment does not occur by screening enrollment requests against the AIDS Waiver enrollee file.

The State pays Waiver agencies for administrative and case management services on the basis of monthly administrative and case management flat fees per eligible enrolled Waiver client. All other Waiver services are reimbursed at cost, but not in excess of the rates established in the AIDS Waiver Service Rate Schedule. Waiver services provided by organized health care delivery systems are submitted by the agencies to the State's fiscal intermediary, Electronic Data Systems, for Medi-Cal services on standard outpatient claim forms or by using computer media claim (CMC) submissions. Providers must use procedure codes (listed below) provided by the State, follow standard Medi-Cal procedures, and file all claims in accordance with the timeframes identified in Medi-Cal policies and regulations.

Case Management	Z5000	Skilled Nursing (RN)	Z5002
Skilled Nursing (LVN)	Z5004	Psychotherapy	Z5006
Attendant Care	Z5008	Homemaker Services	Z5010
Medi-Cal Supplement for Infants and Children in Foster Care			Z5012
Medical Equipment & Supplies/Minor Physical Adaptations			Z5014

Non-Emergency Medical Transportation	Z5016
Administrative Expenses	Z5018
Nutritional Counseling	Z5020
Nutritional Supplements/Home Delivered Meals	Z5022
Combined Waiver Services Calendar Year CAP (excluding Z5018)	Z5000-Z5022

2. The following is a description of all records maintained in connection with an audit trail. Check one:

   _X_ All claims are processed through an approved MMIS.

   ___ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

   ____ The Medicaid agency will make payments directly to providers of waiver services.

   _X_ The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

   ____ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

   ____ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

   ____ Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

APPENDIX G - FINANCIAL DOCUMENTATION
APPENDIX G-1 COMPOSITE OVERVIEW, COST NEUTRALITY FORMULA

AGGREGATE LEVEL OF CARE:

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1 (2000) BASE	$3,694	$21,718	$81,077	$11,702
2 (2002)	$3,420	$29,402	$97,607	$15,677
3 (2003)	$3,391	$34,207	$107,073	$18,141
4 (2004)	$3,354	$39,806	$117,493	$20,999
5 (2005)	$3,319	$46,317	$128,881	$24,299
6 (2006)	$3,286	$53,885	$141,442	$28,126

Explanation of the Basis for Estimating Factors D, D', G, and G'--Data was trended for CYs 1998 through 2000. The average annual percent change for CYs 1998 – 2000 was used to trend Factors C', A, A', and "372 Total Expenditures" with the following additions for CY 2002: i) Factor C' includes an additional 300 recipients; and ii) "372 Total Expenditures" for Factors C and C' include costs for an additional 300 recipients. The State trended Factor C using: i) the actual number of unduplicated recipients for CY 2001 (e.g. 2,731 recipients); ii) a projected increase of 2.4% (rounded to the nearest 10 beneficiaries) plus 300 beneficiaries for CY 2002; and iii) a projected annual increase of 2.4% (rounded to the nearest 10 beneficiaries) for CYs 2003 – 2006.

- **Factor D:** The average percent change in total recipients (Factor C) and 372 Total Expenditures is estimated to increase by 2.4 and 1.4 percent respectively *(plus 300 additional recipients and their 372 Total Expenditures for CY 2002)*. 372 Total Expenditures were divided by Factor C to obtain Factor D Annual per Capita for each CY. It is estimated that Factor D will decrease slightly each year dependent on the trended increases for Factor C and 372 Total Expenditures for each CY

- **Factor D':** The average percent change in total recipients (Factor C') and 372 Total Expenditures is estimated to increase 1.5 and 18.1 percent respectively *(plus 300 additional recipients and their 372 Total Expenditures for CY 2002)*. 372 Total Expenditures were divided by Factor C' to obtain Factor D' Annual per Capita for each CY. It is estimated that Factor D' will increase each year with the percentage increase dependent on the trended increase for Factor C' and 372 Total Expenditures for each CY.

- **Factor G:** The average percent change in total recipients (Factor A) and 372 Total Expenditures is estimated to increase by 12.9 and 23.9 percent respectively. 372 Total Expenditures were divided by Factor A to obtain Factor G Annual per Capita for each CY. It is estimated that Factor G will increase each year with the percentage increase dependent on the trended increase for Factor A and 372 Total Expenditures for each CY.

- **Factor G':** The average percent change in total recipients (Factor A') and 372 Total Expenditures is estimated to increase by 12.9 and 30.7 percent respectively. 372 Total Expenditures were divided by Factor A' to obtain Factor G'. It is estimated that Factor G' will increase each year with the percentage increase dependent on the trended rate of increase for Factor A' and 372 Total Expenditures for each CY.

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR UNDUPLICATED INDIVIDUALS

	AGGREGATE
BASE (2001)	2,731
1 (2002)	3,100
2 (2003)	3,170
3 (2004)	3,250
4 (2005)	3,330
5 (2006)	3,410

EXPLANATION OF FACTOR C:

Check one:

__X__ The State will make waiver services available to individuals in the target group up to the number indicated as Factor C for the waiver year. The actual number of Waiver recipients enrolled through December 31, 2001 for CY 2001 was 2,731 recipients. For CY 2002, the State is projecting a 2.4% percent increase (rounded to the nearest 10) plus an additional 300 recipients. For CYs 2003 – 2006 the State is projecting a 2.4% increase in the number of Waiver recipients each CY (rounded to the nearest 10).

____ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit that is more than factor C for that waiver year.

APPENDIX G-2, FACTOR D LOC: AGGREGATE

WAIVER SERVICES	Year	Column A # of Undup. Recipients (Rounded)	Column B Avg. Annual Units/Users (Rounded)	Column C Average Unit Cost (Rounded)	Column D Total Expenditures (Rounded)
Case Management	2002	3,091	6.68 units	$229.17	$4,731,335
CY 00: 99.722% Total Recp & 44.6329% Grand Total Exp	2003	3,161	6.63 units	$229.17	$4,797,573
$229.17 monthly flat fee per client	2004	3,241	6.55 units	$229.17	$4,864,739
	2005	3,321	6.48 units	$229.17	$4,932,846
	2006	3,401	6.42 units	$229.17	$5,001,906
Skilled Nursing	2002	144	20.24 hrs.	$36.85	$107,415
CY 00: 4.6465% Total Recp & 1.0133% Grand Total Exp	2003	147	20.10 hrs.	$36.85	$108,919
LVN = @ $29.41 hr., RN = $40.57	2004	151	19.85 hrs.	$36.85	$110,444
Column C is an average or LVN and RN rates.	2005	154	19.73 hrs.	$36.85	$111,990
	2006	158	19.50 hrs.	$36.85	$113,558
Attendant Care	2002	1,201	195.08 hrs.	$18.90	$4,428,265
CY 00: 38.7609% Total Recp & 41.7739% Grand Total Exp.	2003	1,229	193.31 hrs.	$18.90	$4,490,261
$18.90 hr. maximum	2004	1,260	191.20 hrs.	$18.90	$4,553,124
	2005	1,291	189.22 hrs.	$18.90	$4,616,868
	2006	1,322	187.36 hrs.	$18.90	$4,681,504
Psychotherapy	2002	681	11.99 hrs.	$51.00	$416,284
CY 00: 21.9619% Total Recp & 3.927% Grand Total Exp.	2003	696	11.89 hrs.	$51.00	$422,112
$51.00 hr. maximum	2004	714	11.75 hrs.	$51.00	$428,021
	2005	731	11.64 hrs.	$51.00	$434,014
	2006	749	11.52 hrs.	$51.00	$440,090
Homemaker Services	2002	236	124.12 hrs.	$11.56	$338,624
CY 00: 7.6251% Total Recp & 3.1944% Grand Total Exp.	2003	242	122.74 hrs.	$11.56	$343,365
$11.56 hr. maximum	2004	248	121.44 hrs.	$11.56	$348,172
	2005	254	120.24 hrs.	$11.56	$353,046
	2006	260	119.10 hrs.	$11.56	$357,989
Minor Physical Adaptations/Specialized Medical	2002	131	2.17 units	$72.46	$20,597
Equipment and Supplies	2003	135	2.13 units	$72.63	$20,885
CY 00: 4.2494% Total Recp & .1943% Grand Total Exp.	2004	138	2.11 units	$72.73	$21,178
$1,000/client per year combined maximum.	2005	142	2.08 units	$72.70	$21,474
Column C based on CY 2000 data from fiscal intermediary.	2006	145	2.07 units	$72.55	$21,775
Medi-Cal Supplement for Infants and Children in Foster	2002	7	3.07 units	$338.00	$7,272
CY 00: .0024% Total Recp & .0686% Grand Total Exp.	2003	8	2.73 units	$338.00	$7,374
$338/client/month maximum. Column C based on CY 2000	2004	8	2.77 units	$338.00	$7,477
data from fiscal intermediary. The expenditures for this	2005	8	2.80 units	$338.00	$7,582
service were adjusted so Column D totals add.	2006	8	2.84 units	$338.00	$7,688
NonEmergency Medical Transportation	2002	1,056	5.39 units	$25.92	$147,560
CY 00: 34.0747% Total Recp & 1.392% Grand Total Exp.	2003	1,080	5.34 units	$25.94	$149,626
$40/client/month maximum.	2004	1,107	5.29 units	$25.91	$151,720
Column C based on CY 2000 data from fiscal intermediary.	2005	1,135	5.23 units	$25.92	$153,844
	2006	1,162	5.18 units	$25.92	$155,998
Nutritional Counseling	2002	107	2.39 hrs.	$33.48	$8,544
CY 00: .0346% Total Recp & .0806% Grand Total Exp.	2003	110	2.35 hrs.	$33.48	$8,664
$33.48 hr. maximum	2004	112	2.34 hrs.	$33.48	$8,785
	2005	115	2.31 hrs.	$33.48	$8,908
	2006	118	2.29 hrs.	$33.48	$9,033
Nutritional Supplements/Home Delivered Meals	2002	956	6.72 units	$61.43	$394,659
CY00: 30.8578% Total Recp & 3.723% Grand Total Exp.	2003	978	6.67 units	$61.35	$400,184
$150/client/month maximum.	2004	1,003	6.59 units	$61.39	$405,786
Column C based on CY 2000 data from fiscal intermediary.	2005	1,028	6.52 units	$61.39	$411,467
	2006	1,051	6.47 units	$61.36	$417,228
Total of Column C	2002	$10,600,554			
	2003	$10,748,962			
	2004	$10,899,447			
	2005	$11,052,039			
	2006	$11,206,768			
Factor C	2002	3,100			
	2003	3,170			
	2004	3,250			
	2005	3,330			
	2006	3,410			
Factor D (Column C Total Divided by Factor C)	2002	$3,420			
	2003	$3,391			
	2004	$3,354			
	2005	$3,319			
	2006	$3,286			

APPENDIX G-3
METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

Case management, homemaker, environmental accessibility adaptations, skilled nursing, non-emergency medical transportation, specialized medical equipment and supplies, attendant care, psychotherapy, Medi-Cal supplement for infants and children in foster care, nutritional supplements, home delivered meals, and nutritional counseling.

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

N/A

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

APPENDIX G-4
METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

X The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

___ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5

FACTOR D'

LOC: **Acute, NF, and Aggregate**

Factor D' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

__X__ Based on HCFA Form 372 for year Base Year 2000) of waiver # 0183.90.R1, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

___ Other (specify):

APPENDIX G-6
FACTOR G

LOC: **Acute, NF, and Aggregate**

The July 25, 1994 final regulation defines Factor G as:

> "The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

___ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

X Based on trends shown by HCFA Form 372 for year Base Year (2000) of waiver #0183.90.R1, which reflect costs for an institutionalized population at this LOC. Each day of waiver participation would, in the absence of the waiver, be a day of institutional stay. As a result, Factor G equals total institutional costs for all unduplicated non-waiver Medi-Cal beneficiaries:

A) With Definitive HIV/AIDS ICD-9-CM diagnosis codes, or HIV-Specific Laboratory Testing Codes, or HIV-Specific Drug Codes, or Comparable (non-AIDS) ICD-9-CM codes *(see Appendix G-8, Pages 78-79)*; and
B) Who have been institutionalized in Acute or Nursing Facility level of care for at least 180 days in the calendar year.

___ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

___ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

___ Other (specify):

_____

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7

FACTOR G'

LOC: **Acute, NF, and Aggregate**

Factor G' is computed as follows (check one):

__ Based on HCFA Form 2082 (relevant pages attached).

X Based on HCFA Form 372 for year Base Year (2000) of waiver # 0183.90.R1, which serves a similar target population. Each day of waiver participation would, in the absence of the waiver, have otherwise been a day of institutional stay. As a result, Factor G' equals State Plan ancillary service costs (excluding hospice services) for Factor G beneficiaries for the same number of service days as the average number of service days of ancillary costs captured for waiver beneficiaries in the same calendar year. The final Form CMS-372S for Calendar Years 1996 through 2000 reflecting this Factor G' will be transmitted to CMS during April 2002.

__ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

__ Other (specify):

APPENDIX G-8, DEMONSTRATION OF COST NEUTRALITY

Base Year 2000	**Aggregate**
Factor D	$3,694
Factor D’	$21,718
Total	**$25,412**
Factor G	$81,077
Factor G’	$11,702
Total	**$92,779**
Base Year 2002	**Aggregate**
Factor D	$3,420
Factor D’	$29,402
Total	**$32,822**
Factor G	$97,607
Factor G’	$15,677
Total	**$113,284**
Base Year 2003	**Aggregate**
Factor D	$3,391
Factor D’	$34,207
Total	**$37,598**
Factor G	$107,073
Factor G’	$18,141
Total	**$125,214**
Base Year 2004	**Aggregate**
Factor D	$3,354
Factor D’	$39,806
Total	**$43,160**
Factor G	$117,493
Factor G’	$20,099
Total	**$138,492**
Base Year 2005	**Aggregate**
Factor D	$3,319
Factor D’	$46,317
Total	**$49,636**
Factor G	$128,881
Factor G’	$24,299
Total	**$153,180**
Base Year 2006	**Aggregate**
Factor D	$3,286
Factor D’	$53,885
Total	**$57,171**
Factor G	$141,422
Factor G’	$28,126
Total	**$169,548**

APPENDIX G-8
DEMONSTRATION OF COST NEUTRALITY
LOC: Acute, NF, and Aggregate

FORMULA FOR WEIGHTED FACTOR D *(Per State Medicaid Manual 4442.8)*

D.1 Total Waiver Service Expenditures ($) per calendar year
D.2 Total unduplicated Waiver beneficiaries per calendar year
D.3 D.1 divided by D.2

FORMULA FOR WEIGHTED FACTOR D'

D'.1 Total State Plan ancillary expenditures ($) for all unduplicated waiver beneficiaries, excluding Certified Hospice Service, for dates of service [DOS] in the waiver.
D'.2 Unduplicated waiver beneficiaries disenrolled, institutionalized *(in Acute, SNF, ICF, or ICF-MR),* and re-enrolled in waiver in same calendar year
D'.3 Total institutional expenditures ($) for D'.2 *(no ancillaries for DOS in institution)*
D'.4 D'.1 + D'.3
D'.5 D'.4 divided by D.2 *(total unduplicated waiver beneficiaries per calendar year)*

FORMULA FOR WEIGHTED FACTOR G

G.1 A) All non-waiver Medi-Cal beneficiaries with any of the attached:
i) Definitive HIV/AIDS ICD-9-CM diagnosis codes; or
ii) HIV-Specific Laboratory Testing Codes; or
iii) HIV-Specific Drug Codes; or
iv) Comparable (non-AIDS) ICD-9-CM diagnosis codes; and
B) who have been institutionalized in Acute, SNF, ICF, ICF-MR, or any combination of these facilities, for at least 180 days in the calendar year.
G.2 Total institutional costs in the calendar year for G.1
G.3 G.2 divided by G.1

FORMULA FOR WEIGHTED FACTOR G'

G'.1 Average days of service (DOS) in the waiver per waiver beneficiary in D.2 (e.g. total waiver DOS for the calendar year divided by D.2)
G'.2 Total ancillary $ for all beneficiaries in G.2 for the calendar year
G'.3 G'.1 divided 365
G'.4 G'2 multiplied by G'.3

DEFINITIVE HIV/AIDS DIAGNOSIS CODES AND COMPARABLE DISEASE DIAGNOSIS CODES

Definitive HIV/AIDS ICD-9-CM Codes

ICD-9-CM Codes	Description
042, 0420, 0421, 0422, 0429	HIV disease, AIDS, AIDS like syndrome, AIDS-related complex, ARC, symptomatic HIV infection—replaced with a single code 042
043, 0430, 0431, 0432, 0433, 0439	HIV infection causing other specified conditions
044, 0440, 0449	Other HIV infection
136.3	Pneumocystosis Carinii Pneumonia
795.71	Non specific serological evidence of HIV—applicable only to those patients who test positive on a preliminary screening test but whose HIV infection status is not yet confirmed
795.8	Positive serological or viral culture findings for HIV—replaced by 795.71
VO8	Asymptomatic HIV infection status

HIV-SPECIFIC LABORATORY TESTING (CDC, Lisa M. Lee, PhD, 3/15/99)

CPT Codes	Description
87534	DNA or RNA detection; HIV 1 direct probe
87535	DNA or RNA detection; HIV 1 amplified probe
87536	DNA or RNA detection; HIV 1 quantification
87537	DNA or RNA detection; HIV 2 direct probe
87538	DNA or RNA detection; HIV 2 amplified probe
87539	DNA or RNA detection; HIV 2 quantification

HIV-SPECIFIC DRUG CODES (Wes Patterson, Research & Evaluation, OA, 323-4322 8/01)

NDC	Generic Name	Label Name
00173067200	AMPRENAVIR/VITAMIN E	AGENERASE 150MG CAPSULE
00173068700	AMPRENAVIR/VITAMIN E/PROP GLY	AGENERASE 15MG/ML ORAL SOLUTION
00173067900	AMPRENAVIR/VITAMIN E	AGENERASE 50MG CAPSULE
00173059500	ZIDOVUDINE/LAMIVUDINE	COMBIVIR TABLET
00173059502	ZIDOVUDINE/LAMIVUDINE	COMBIVIR TABLET
54569452401	COMBIVAR	COMBIVAR 150/300MG TABLET
55289038906	COMBIVAR	COMBIVAR TABLET
00006057062	INDINAVIR SULFATE	CRIXIVAN 100MG CAPSULE
00006057143	INDINAVIR SULFATE	CRIXIVAN 200MG CAPSULE
00006057142	INDINAVIR SULFATE	CRIXIVAN 200MG CAPSULE
00006057465	INDINAVIR SULFATE	CRIXIVAN 333MG CAPSULE
00006057340	INDINAVIR SULFATE	CRIXIVAN 400MG CAPSULE
00006057342	INDINAVIR SULFATE	CRIXIVAN 400MG CAPSULE
00006057354	INDINAVIR SULFATE	CRIXIVAN 400MG CAPSULE
00006057362	INDINAVIR SULFATE	CRIXIVAN 400MG CAPSULE
00006057318	INDINAVIR SULFATE	CRIXIVAN 400MG CAPSULE
00173047100	LAMIVUDINE	EPIVIR 10MG/ML ORAL SOLN
00173047001	LAMIVUDINE	EPIVIR 150MG TABLET
00173066200	LAMIVUDINE	EPIVIR HBV 100MG TABLET
00173066300	LAMIVUDINE	EPIVIR 5MG/5ML SOLUTION
00004024648	SAQUINAVIR	FORTOVASE 200MG SOFTGEL CAP
00004022001	ZALCITABINE	HIVID 0.375MG TABLET
00004022101	ZALCITABINE	HIVID 0.750MG TABLET
00004024515	SAQUINAVIR MESYLATE	INVIRASE 200MG CAPSULE
00074395646	RITONAVIR/LOPINAVIR	KALETRA ORAL SOLUTION
00074395977	RITONAVIR/LOPINAVIR	KALETRA SOFTGEL
00074949202	RITONAVIR	NORVIR 100MG CAPSULE
00074663322	RITONAVIR	NORVIR 100MG SOFTGEL CAP
00074194063	RITONAVIR	NORVIR 80MG/ML SOLUTION
0074949254	NORVIR	NORVIR 100MG CAPSULE
00009376103	DELAVIRDINE MESYLATE	RESCRIPTOR 100MG TABLET
00009757601	DELAVIRDINE MESYLATE	RESCRIPTOR 200MG TABLET
00081010855	ZIDOVUDINE	RETROVIR 100MG CAPSULE
00081010856	ZIDOVUDINE	RETROVIR 100MG CAPSULE
00173010855	ZIDOVUDINE	RETROVIR 100MG CAPSULE
00173010856	ZIDOVUDINE	RETROVIR 100MG CAPSULE
00081011318	ZIDOVUDINE	RETROVIR 10MG/ML SYRUP
00173011318	ZIDOVUDINE	RETROVIR 10MG/ML SYRUP
00173050100	ZIDOVUDINE	RETROVIR 300MG TABLET
00173010793	ZIDOVUDINE	RETROVIR IV INFUSION VIAL
00081010793	ZIDOVUDINE	RETROVIR IV INFUSION VIAL

00056047330	EFAVIRENZ	SUSTIVA 100MG CAPSULE
00056047492	EFAVIRENZ	SUSTIVA 200MG CAPSULE
00056047030	EFAVIRENZ	SUSTIVA 50MG CAPSULE
00173069100	ZIDOVUDINE/LAMIVUDINE/ ABACAVIR	TRIZIVIR TABLET
00087661443	DIDANOSINE/SODIUM CITRATE	VIDEX 100MG PACKET
00087665201	DIDAN/CALCIUM CARB/MAGNESIUM	VIDEX 100MG TABLET CHEWABLE
00087662743	DIDAN/NACT(ALK)/MG(A)/ AL NACB	VIDEX 100MG TABLET CHEWABLE
00087665301	DIDAN/CALCIUMCARB/ MAGNESIUM	VIDEX 150MG TABLET CHEWABLE
00087662643	DIDAN/NACT(ALK)/MG(A)/ AL NACB	VIDEX 150MG TABLET CHEWABLE
00087661543	DIDANOSINE/SODIUM CITRATE	VIDEX 167MG PACKET
00087666515	DIDAN/CALCIUM CARB/MAGNESIUM	VIDEX 200MG TABLET CHEWABLE
00087661643	DIDANOSINE/SODIUM CITRATE	VIDEX 250MG PACKET
00087665001	DIDAN/CALCIUM CARB/ MAGNESIUM	VIDEX 25MG TABLET CHEWABLE
00087662843	DIDAN/NACT(ALK)/MG(A)/AL NACB	VIDEX 25MG TABLET CHEWABLE
00087663241	DIDANOSINE	VIDEX 2GM PEDIATRIC SOLN
00087663341	DIDANOSINE	VIDEX 4GM PEDIATRIC SOLN
00087665101	DIDAN/CALCIUM CARB/MAGNESIUM	VIDEX 50MG TABLET CHEWABLE
00087662443	DIDAN/NACT(ALK)/MG(A)/ AL NACB	VIDEX 50MG TABLET CHEWABLE
00087667117	DIDANOSINE	VIDEX EC 125MG CAP SA
00087667217	DIDANOSINE	VIDEX EC 200MG CAP SA
00087667317	DIDANOSINE	VIDEX EC 250MG CAP SA
00087667417	DIDANOSINE	VIDEX EC 400MG CAP SA
63010001030	NELFINAVIR MESYLATE	VIRACEPT 250MG TABLET
63010001027	NELFINAVIR MESYLATE	VIRACEPT 250MG TABLET
63010001190	NELFINAVIR MESYLATE	VIRACEPT POWDER
00597004661	NEVIRAPINE	VIRAMUNE 200MG TABLET
00054464725	NEVIRAPINE	VIRAMUNE 200MG TABLET
00054464721	NEVIRAPINE	VIRAMUNE 200MG TABLET
00054864725	NEVIRAPINE	VIRAMUNE 200MG TABLET
00597004660	NEVIRAPINE	VIRAMUNE 200MG TABLET
00597004601	NEVIRAPINE	VIRAMUNE 200MG TABLET
00054390558	NEVIRAPINE	VIRAMUNE 50MG/5ML SUSP
00597004724	NEVIRAPINE	VIRAMUNE 50MG/5ML SUSP
00003196401	STAVUDINE	ZERIT 15MG CAPSULE
00003196801	STAVUDINE	ZERIT 1MG/ML SOLUTION
00003196501	STAVUDINE	ZERIT 20MG CAPSULE
00003196601	STAVUDINE	ZERIT 30MG CAPSULE
00003196701	STAVUDINE	ZERIT 40MG CAPSULE
00173066400	ABACAVIR SULFATE	ZIAGEN 20MG/ML SOLUTION
00173066100	ABACAVIR SULFATE	ZIAGEN 300MG TABLET
00173066101	ABACAVIR SULFATE	ZIAGEN 300MG TABLET

COMPARABLE ICD-9-CM DIAGNOSIS CODES

The following conditions/diseases have compromised cellular immunity that can cause an increased incidence of opportunistic infections and/or affect a compromised immune system like HIV/AIDS but also may cause other diseases.

ICD-9-CM Codes	Description
279.04	Infantile X-linked Agammaglobulinemia
279.11	Thymic Hypoplasia (DiGeorge's Syndrome)
279.2	Severe Combined Immuno-deficiency
334.8	Immunodeficiency with Ataxia-Telangiectasia
287.3, 288.0	Primary Acquired Agammaglobulinemia
135	Immunodeficiency Associated with Sarcoidoisis
201	Immunodeficiency Associated with Hodgkin's Disease
288.8	Idiopathic CD4 lymphophenia
279.20	Severe Combined Immunodeficiency
279.12	Wiskott-Adrich Syndrome (rare)
996.85	Bone Marrow Transplantation (immune system abated and then reconstituted from exogenous source)
996.80, 996.81, 996.82, 996.83, 996.84, 996.86, 996.87, and 996.89	Solid Organ Transplantation (innate immune system intentionally compromised to prevent rejection) (unspecified, kidney, liver, heart, lung, pancreas, intestine, other organ)
334.8	Ataxia-Telangiectasia